Maryland Immunization Information System (ImmuNet)
Rescind Opt-out Form

Maryland's Immunization Information System (ImmuNet) is a secure health information system containing the names and immunization history of people who have received vaccinations in Maryland. This information is available only to authorized health care providers, child care providers, and schools. Participation in ImmuNet is voluntary and you may opt out for yourself or your child at any time by completing the Opt-out form, or rescind the opt-out and have your/your child's information made available to your/your child's health care provider(s).

You may download and print this form, or request a hard copy by contacting the ImmuNet Help Desk at dhmh.mdimmunet@maryland.gov or 410-935-9295.

Please complete the information for the person whose immunization record be made available to participants of the ImmuNet program.

Client Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email address: _____

Information about the person completing this form
Information about the person completing the rescind opt-out request (this information will be used to contact you if this form is incomplete or unclear, and will be filed as legal documentation of the rescind opt-out request).

☐ Same as Client Information above (if not, please provide the information below)

Relationship to client: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email address: _____

Signature

By checking the box below, I confirm that I am the individual or parent/legal guardian of the client listed above. I had chosen to have the immunization information for myself/my child excluded from healthcare providers' access, however, at this time, I would like to have my/my child's immunization information be made available to my/my child's health care provider(s).

I agree: ☐

I declare under penalty of perjury under the laws of the state of Maryland that this information is true and correct, and that I am the client, or am authorized to make decisions for the client listed on this form.

Signature of Person Rescinding the Opt-out: _____

Date completed: _____

If you wish to keep a completed copy of your form, please make a copy before submitting the form.

Mail or Fax to

Maryland Department of Health and Mental Hygiene
Center for Immunization - ImmuNet
201 West Preston Street 3rd Floor, Baltimore, MD 21201
Fax: (410) 333-5893